



## Durable Medical Equipment (DME) and Supplies (Rev. October 2014)\

<b>Patient Name, Address, Telephone Number, Date of Birth</b>  <b>Medicaid ID Number</b> _____ <b>Other Insurance</b> _____	<b>Supplier Name, Address, Telephone Number</b>  <b>NPI Number</b> _____ <b>Physician Name, Address, Telephone Number</b> _____																																																																																																																
<b>Residence</b> <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital <input type="checkbox"/> Rehab Unit <input type="checkbox"/> Group Home <input type="checkbox"/> Other _____																																																																																																																	
Does the patient have the ability to operate/use this requested item as intended by the items manufacture? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																	
Has the patient received a trial use of this item? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long? _____      Was the item billed to Medicaid as a rental during the trial use period? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																	
Is the product or its components covered by a warranty? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, attach warranty information.</b>																																																																																																																	
<h3>Specification List</h3> <p><b>NOTE: All billable items that make up this request must be listed individually below. Any item that is not listed below is subject to recovery if added and billed to Medicaid at a later time.</b> If additional space is needed, a continued sheet can be attached to this document as long as the pertinent patient and supplier information is included at the top of the attachment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">DOS</th> <th style="width: 15%;">LEVEL II CODE</th> <th style="width: 30%;">DESCRIPTION</th> <th style="width: 20%;">MANUFACTURER</th> <th style="width: 10%;">PRODUCT #</th> <th style="width: 10%;">UNITS</th> <th style="width: 10%;">LIST PRICE</th> <th style="width: 5%;">DEPT. USE ONLY</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>		DOS	LEVEL II CODE	DESCRIPTION	MANUFACTURER	PRODUCT #	UNITS	LIST PRICE	DEPT. USE ONLY																																																																																																								
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I certify that the information contained in this document and its attachments/supporting documents are true, accurate, and complete, to the best of my knowledge. I further certify that all measurements, fitting, assembly, and adjustments have been completed, or will be completed upon delivery. I understand my responsibility to train the patient and/or caregiver in the proper use and advise any safety issues of the requested item. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.																																																																																																																	
<b>Signature and date stamps are not acceptable.</b>  <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%; text-align: center;">           _____            Supplier Signature         </div> <div style="width: 45%; text-align: center;">           _____            Date         </div> </div>																																																																																																																	
<b>Attachments:</b> This form must be accompanied by copies of supporting documentation to justify the medical need of the requested items. Supporting documentation includes, but is not limited to a prescription, Certificate of Medical Need (if required of the item), and a narrative description detailing the need for the item from the patient's primary care provider. If the patient is being treated by a licensed therapist, a copy of the patient's plan of care and a narrative summary supporting this request is required.																																																																																																																	